

**MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN  
SERVICES**

Quality Assurance Division – Licensure Bureau  
2401 Colonial Drive, PO Box 202953  
Helena MT 59620-2953  
FAX: (406) 444-1742

**APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE  
ADULT DAY CARE LICENSE APPLICATION**

**Initial Application** ☐

**Renewal Application** ☐

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_ PO Box \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Facility Telephone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

Facility E-mail/Web page Address : \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Applicant Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Applicant (or contact) e-mail address: \_\_\_\_\_

Name of Administrator: \_\_\_\_\_

Administrator Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Administrator e-mail: \_\_\_\_\_

**Number of clients served / licensed for:** \_\_\_\_\_

**Hours of Operation:** \_\_\_\_\_

**Will this be a freestanding facility?**

**YES** ☐

**NO** ☐

**If No, what facility is the Adult Day Care connected to:**

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Facility Telephone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

Facility E-mail/Web page Address: \_\_\_\_\_

**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

Quality Assurance Division—Licensure Bureau

**Operating Organization**

**Information on ownership, contract or lease agreement if operated by a person other than the owner:**

- ☐ **If a partnership, firm or association. List every member thereof.**  
☐ **If a corporation. List the name and address thereof and the names of its officers.**  
☐ **State Affiliated Organization**

NAME

ADDRESS

*I certify that all information submitted to DPHHS is true and correct. This Application for license for an Adult Day Care is hereby submitted under the provision of Section 50-5-101 through 50-5-208.*

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE/ZIP: \_\_\_\_\_

Enclose a check, money order or draft made payable to the Department of Public Health & Human Services to cover the license fee. The fee is determined as follows:

(a) facilities with 20 or less = \$20.00

(b) facilities with 21 clients / beds or more = \$1.00 per client / bed.

This fee will be deposited in the State Treasury and is non-refundable.